CHANGING PATTERNS OF NURSING

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the medical missionary

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THE WORLD NEEDS NURSES

EDITORIAL

"Times change and we change with them," says the old proverb. In this modern world, change is an almost daily companion—constantly with us. Its revolutionizing force has penetrated all structures of society, all patterns of thought, all the values of man—social, cultural, religious throughout the ages.

The vital fields of medicine and health have specially shared in the social and industrial upheavals of our times. Never has the pace of change in medical history been so rapid as in this last decade —new scientific discoveries, new life-saving drugs and treatments, new antibiotics, new techniques in surgery, new mechanical time-saving devices for patients, new hospital insurance plans. Medical men in our changing times have even dared to face the challenge of atomic and space medicine, and health in the higher spheres.

With the rapid changes in the medical world, it is very natural that nursing arts and nursing education have also had to change to equip the modern professionally trained nurse to keep up with the growing demands for greater responsibility and increased knowledge.

The profession of modern nursing is very young. Schools for nurses in this country were opened less than 100 years ago. Few people realize how enormous have been the changes in the education of nurses in each decade since then. Today we have 390,000 active registered nurses in the United States and all signs indicate that the need for nurses in the future will become more rather than less due to the fast birth rate and greatly lengthened life span.

Nursing education and arts have changed but the Christian spirit of nursing must be kept intact. Owing to the great need for nurses in the modern world, says Rev. Leo Zodrow, S.J., in a recent article, there is a tendency to regard the vocation of nursing as just another career and attempts are being made to split up the nurse's duties into specialized functions so that the "personal element in her ministrations is to all intents and purposes destroyed." "The ward becomes a conveyer belt," he states, "with one difference, it is the nurse who moves along the line, and the hospital becomes a fully mechanized factory. Hospital techniques do not of themselves endanger the human being, but the mechanization of human work spells disaster to all true nursing."

The service of the sick, Father Zodrow warns, is not a trade, it is more than the mastering of nursing techniques and it calls for special human qualifications. Its special dignity stems from the fact that it is offered directly to a human person, as the work of a priest, or doctor.

For the Christian nurse, like Veronica, there is only one patient—the suffering Christ. And because the nurse's calling belongs to the religious and the sacred, only the truly religious nurse can resist the inherent dangers of dehumanization and the patterns of cold professionalism

which accompanies so much of our technical and mechanical progress today. It is not the techniques that are evil in themselves—it is the way they are used by the individual. In the modern streamlined, efficient hospital there is danger of the patient becoming just a cog in a big machine. The patient has a number, his diagnosis is given a number, he is subjected to innumerable chemical tests. His dignity as a human being, an individual of body and soul can easily be lost. Here the nurse, with a deeply imbedded Christian spirit of nursing, based on Divine Charity—has a key position—a vital role to play in preserving and saving the humaneness and Christian dignity of her patients.

* * *

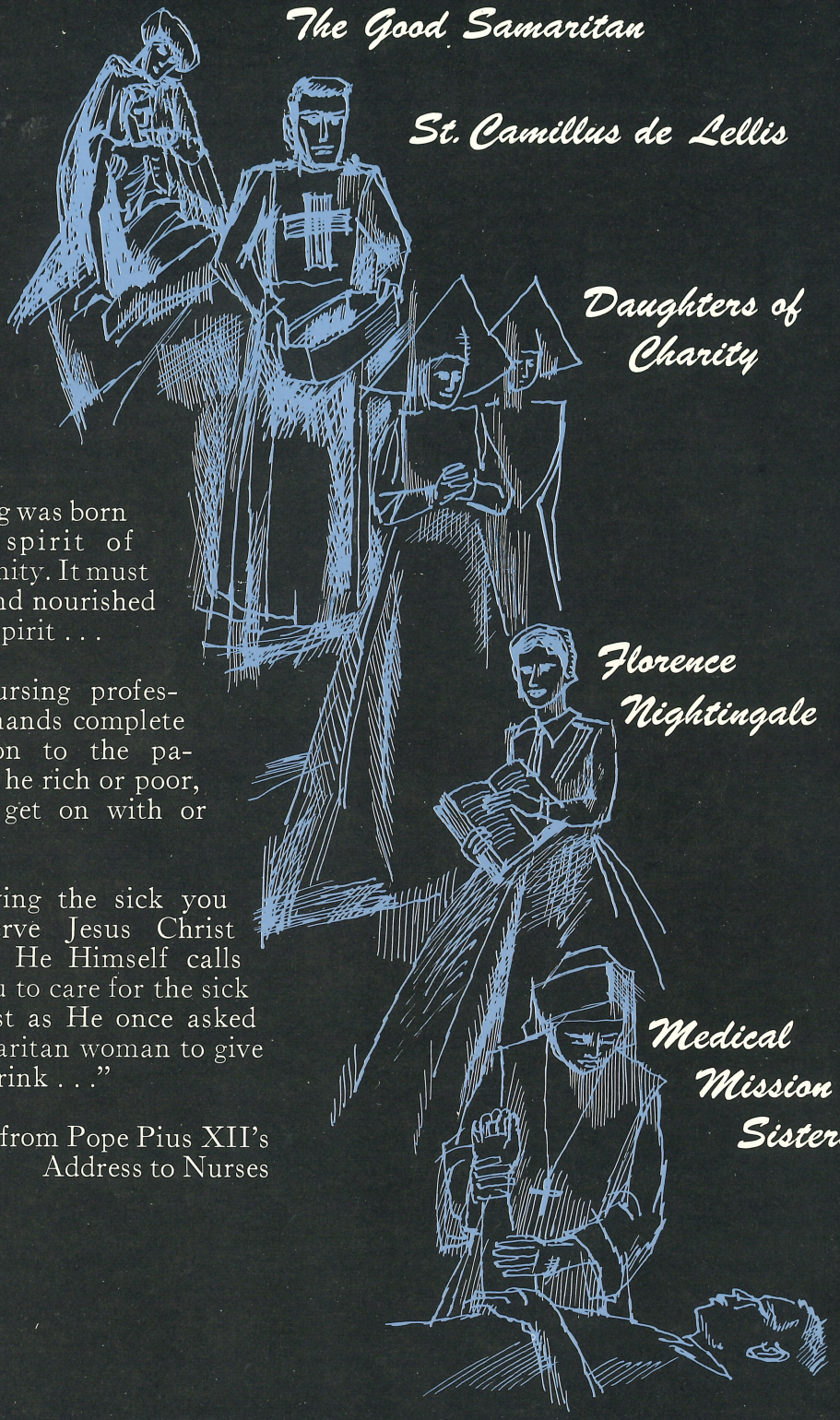
While nursing education and techniques have advanced rapidly over here, in some countries the profession is just being born. The call for qualified nurses is resounding all over the world today. The leaders of most countries now realize that the economic future of their nations is integrally related to the health and well being of their people. They are making every effort to improve professional training where it already exists or to begin to organize programs of training.

As in the West, a century ago, nursing and similar health work in India and Pakistan is only slowly becoming a socially accepted or adequately paid occupation for women. Today in India there is only one trained nurse for every 20,000 persons as compared to one for 250 in the United States. This is only a fourth as many nurses as are needed. In Pakistan which only began its life as a country and its own nursing service in 1947, there is only one nurse for 40,000 persons. The need here is very great as the Public Health problems in this new undeveloped country are very great.

In Vietnam, there were no modern schools of nursing at all before 1951. Modern nursing had not been introduced. Most of the care of the sick was done by men and their duties consisted of assisting the doctors in giving medications and treatments. Patient care was left to the relatives who accompanied the patient to the hospital. In many wards there were no mattresses, linen, or water. Today there are two recognized training schools of nurses.

It is hard to believe the need for medical and nursing care in mission countries and the underdeveloped areas of the world and still harder to realize how much poverty and disease still exists there. Yet, some countries still have areas where there are no trained nurses at all.

Toynbee, the historian, has prophesied: "The 20th century will be chiefly remembered, not as an age of political conflict, or technical inventions, but as an age in which human society dared to think of the welfare of the *whole* human race as a practical objective." Surely this presents a challenge to every nurse today to share her professional training and skills with women in other lands. But in handing over her professional knowledge and technical know-how, let her not fail to give them the real heritage and spirit of nursing—the Christian spirit of dedicated and devoted service, based on charity.



"Nursing was born of the spirit of Christianity. It must be fed and nourished by that spirit . . .

"The nursing profession demands complete dedication to the patient, be he rich or poor, easy to get on with or not . . .

"In serving the sick you must serve Jesus Christ Himself. He Himself calls upon you to care for the sick man, just as He once asked the Samaritan woman to give Him a drink . . ."

—from Pope Pius XII's Address to Nurses

CHANGING PATTERNS IN NURSING AND NURSING CARE

Margaret M. Burns, R.N., B.S.N.

A generation ago, the typical nurse functioned as an efficient, tireless and dedicated person, working long enduring hours for a minimum wage, under adverse conditions, which included responsibility for housekeeping chores.

Today's nurse is an independent, highly skilled professional person, with an increased knowledge of the physical, biological and social sciences. Relieved of many non-nursing functions of the past, the modern nurse works shorter hours, and has the time to engage in further study, participate in community affairs and attend professional meetings. The increased status of the nurse as a professional worker, the development of nursing organizations and the improvement in nursing education have contributed immensely to the changing status of the nurse.

Nursing in a modern hospital represents a striking change from the nursing of a few decades ago. Formerly, the nurse was concerned chiefly with caring for the physical needs of the patient and alleviating the symptons of illness. Today's nurse must not only care for the person who is ill but also teach health to the patient and his family, help in the rehabilitation of the patient, and participate with members of the other health professions in preventing disease in the community. In the past the preparation of the nurse was directed mainly towards the acquisition of skills, supported by simple knowledge as would enable her to care for the patient. In order to meet the present demands of comprehensive nursing she needs a type of preparation different from that of her predecessor. Her professional education must be designed to equip her with the competencies needed in the practice of modern nursing as well as to provide for her spiritual, intellectual, emotional, social and cultural development.

Nursing education used to be a learning on-the-job experience. This was followed by the establishment of qualified schools of nursing, in a hospital setting, with an emphasis on meeting the service needs of the institution. Today, with a trend towards higher education in general we see, a rise in the number of nursing schools under the direction of educational institutions. However, it is still the three-year diploma program of nursing, in the hospital setting which continues to provide the greater number of professional nurses.

In the past, the nurse and doctor alone, were involved in the care of patients, today in addition we have social workers, nutritionists, physical therapists, psycholo-

gists and laboratory technicians. This change has increased the nurse's responsibility as a health-team worker and co-ordinator with allied professional groups.

Today we have the greatest number of nurses in history, but yet there is still a shortage of qualified nursing personnel. This shortage of nurses, increased hospital admissions, and health insurance programs in the last decade, have brought about major changes in the administration and distribution of nursing care in the modern hospital. In an attempt to meet the nursing needs of our patients, we have moved into the sphere of "team nursing" with various types of nursing personnel functioning within the limit of their education, experience and ability. The "professional nurse" may be assigned to care for the patient with the less complex nursing problem, and the practical nurse or nurses' aide for the patient with a less complex nursing problem. This team nursing places a new responsibility on the professional nurse for the direction, supervision and education of nursing personnel, who must continue to maintain a warm nurse-patient relationship. For, it is the professional nurse who must carry the responsibility for the supervisory, managerial, and teaching functions related to the care of the patient.

This type of nursing requires the observation and interpretation of significant changes in the patient's condition, the administering of potent drugs, the operating of complicated equipment, the planning and carrying out of prescribed nursing care and continuously, the making of important decisions. Even more essential, is the supportive care provided in meeting the patient's psychological, emotional, and spiritual needs, which is part of the nurse's job today.

In the past, the hospital patient was grouped according to his diagnosis. Today a new approach is emerging in which the patient is grouped according to the type and amount of nursing care he needs. This new approach to patient care—Progressive Patient Care—provides staff, service and facilities organized around the *medical* and *nursing* needs of patient and divided into units of: Intensive Care, Intermediate Care, Self-Care, Home Care and Long Term Care.

Nursing today is much more complex and broader in scope involving not only the curative aspects of illness but also the maintenance and promotion of health. This increased emphasis on health preservation has evolved from our changing social and economic needs. Nursing must meet the needs of our changing population. By 1965 the greater concentration of people will be at both age extremes—old age and infancy.

The nurse today is more actively involved in community health programs for maternal and child care and for the control of communicable diseases. Employed in all areas of the world and in all types and levels of nursing, today's nurse may be a public health nurse, an industrial nurse, a hospital nurse, a nurse educator or a nursing consultant.

The challenge in nursing for the future involves interpretation of concepts of health on a world-wide basis; a deeper understanding of the ways people learn, an increased awareness of the relationship of emotions to illness and health, and a fuller understanding of the use of nuclear energy.

Miss Burns is Clinical Instructor in Misericordia Hospital School of Nursing, Philadelphia, Pa.

CHANGING PATTERNS OF NURSING in India

Sister M. Clare, B.S.N.

It is notable that very remarkable strides have been made in the development of the Nursing profession in India during the past eight or ten years. Encouraging are the steps taken by the government to increase the number of qualified nurses, and to further promote better standards of education. Particular emphasis is being placed on Public Health and all Schools of Nursing are being urged to incorporate it into the basic curriculum, so that the country will soon be producing the "multi-purpose nurse," that is, one able to be used in any situation—hospital—industry—home—school, etc.

The development taking place in Nursing is quite in keeping with the general trend of the country, the essence of which is a progressive spirit to develop all its potentialities—as soon as possible—for the general welfare of all. Even the village people, who still comprise 85% of the population, sense this feeling of urgency to work for better standards of living in order to make the world a better place in which to live.

There are now about 24,000 nurses in the country (India needs 700,000). Despite the fact that 204 Schools of Nursing exist in ten states, it is still impossible to fill all the posts being created by the Five Year Plans. Health facilities, which have been almost entirely absent in the rural area are now being started in village Centers in connection with Community Development Blocks. In order to meet this need, the Indian Nursing Council initiated several years ago the two-year Auxiliary Nurse-Midwife programme which consists of nine months of Midwifery, fifty per cent of which must be domiciliary. The educational requirement is 8th class, and the plan is to use these girls in the village areas on a ratio of 2:1 (two registered nurses to every auxiliary nurse). The government is at present granting financial assistance to hospitals which train such girls, in an effort to speed up production.

It is to be remembered that the Nursing profession in India has been functioning in an organized capacity for over 50 years. The Trained Nurses' Association of India originated in 1908, largely through the efforts of the Protestant missionaries whose leadership in the field has been continuous and outstanding. Miss Alice Wilkinson, a

Capping ceremony, Holy Family Hospital, New Delhi, India. Nurses holding lamps in their hands recite Nightingale pledge.

charter member, still visits India periodically, urging the nurses to work together for better care of the sick. It was she who promoted the establishment of the first College of Nursing in the country, at Delhi University under government auspicies, 12 years ago. Shortly afterwards, a second College of Nursing was started at Vellore, South India by the Protestant missionaries.

The T.N.A.I. has continued to grow in enrollment and scope but is still limited to paid personnel at headquarters level only. The employment of paid workers on a state level is now being urged in order to give more assistance to local problems in certain areas.

Nurses' unions have been introduced in the States of Bihar and Kerala. Interest in the profession itself is only being kept alive by a handful of T.N.A.I. members (Trained Nurses' Association of India) not working in state hospitals, whose aim continues to better standards of nursing care in order to give better care to the sick. Unfortunately up until now, there is no Catholic School of Nursing in Kerala, the most Christian state in India. Until five years ago, over 50% of all Indian nurses were Christian, and ten years ago, the figure was 75%. Muslim custom does not permit girls to depart from the purdah system which requires that they never show their face to any man, except their husbands or near relatives. And even today, though the Muslims are a minority group in India, few enter Nursing. Hindus traditionally have looked down upon Nursing as a menial service rather than a profession. Recent recruitment efforts however have touched them, and now the enrollment in Government Hospital Schools is about 85-80% Hindu. Large stipends and other allowances are attracting more into the field and even then, government is finding it difficult to fill all the posts created by the First and Second Five Year Plans.

There are only six Catholic Schools of Nursing for general training in India —at Guntur, Bezwada, Patna, Mandar, Mokameh and Delhi. Three of these are conducted by the Medical Mission Sisters. A seventh school will begin this year in Mangalore. From all these schools together about 150 girls Catholic Nurses graduate annually. Herein lies a big field for development. More Catholic Schools of Nursing are sorely needed! It is esti-

mated that about 500 Catholic Nurses are graduated each year from government hospitals. Although the professional training itself may be acceptable, the exposure to a non-Christian philosophy of life, and the absence of ethical principles not only deprives these girls of the knowledge of Christian attitudes which they should have, but places them in atmospheres where their moral safety can hardly be guaranteed.

An important factor which limits the number of Catholic Schools of Nursing in India is the dearth of approved Catholic Hospitals. In addition to the requirement of at least 75 beds, training hospitals must also have the required professional services (for example, male patients as well as women and children, proper laboratory and surgical facilities, etc.) and qualified personnel to conduct a school. In the past five years the number of religious communities engaged in nursing has increased considerably.

Another difficulty in attracting girls to Catholic hospitals is the poor economic remuneration. Poverty, a chronic condition throughout the country, limits the amount that patients can afford to pay. Even 25 cents a day is exorbitant for some, and so, hospitals cannot provide adequate salaries. It is a known fact too, that at least 80% of the Nurses in the country are contributing heavily to the support of their families and they are therefore attracted to government hospitals where salaries and amenities are more substantial.

One of the greatest challenges for Catholics at the moment is the government's policy on Family Planning. India is the first country in the world to adopt positive methods of population control on a policy level. Millions of rupees are being spent annually for this purpose, and nurses working in government institutions are involved, more or less directly, either in the Operating Rooms where sterilizations are done, or in Public Health Centers where nurses are expected to teach methods of Family Planning. This, together with undisciplined hostile environments continues to be a mounting threat to the moral welfare of the Catholic nurses throughout the country. To counteract this, greater efforts are being put forth now, to organize small but strong units to supply instruction and guidance to the Catholic Nurses particularly those in state institutions.

One form of assistance which is proving to be a great help to Catholic institutions as well as to the general public is the contribution made by Catholic Relief Services—a world wide agency to distribute charity for American Catholics. It has been particularly helpful in initiating Public Health Projects to be able to distribute milk and wheat or rice to undernourished patients and especially to expectant mothers. This is a very positive programme that helps counter the ill effects of the Birth Control advocates, and gives a helping hand to Catholic Action.

Quality of recruitment has improved in certain ways, and deteriorated in others. It is obvious for example, that many girls enter nursing because of economic necessity. It is interesting to note that in the two colleges of nursing where stipends are *not* given but rather tuition is paid by the students, the quality of recruitment is vastly superior. It is earnestly hoped and prayed therefore that we will soon be able to start a Catholic College of Nursing in India.

IN GHANA

Sister M. Patrick, B.S.N.

Like every other country in the world —there is a shortage of nurses—and Nurse Midwives in Ghana—to meet the health needs of the country. One reason is because extensive education of girls is of comparatively recent origin—within the last ten years. Thus, there were only a few women who were prepared to enter the nursing profession.

Shortly after the end of the second great world conflict the Nurses' Board of the Gold Coast (now Ghana) was established to set standards, examine, and register those who would be certificated to practice nursing in Ghana—following WHO recommendations. Emphasis was to be on smaller local hospitals and Public Health aspects—home visiting, etc. Local Maternity homes with government midwives were already established.

Two grades of Nurses were provided for in an attempt to take care of the Nursing Service needs of the country, and to prepare Ghanaian Nurses to meet with nurses from other countries on a comparable professional level. State Registered Nurse, First Grade of Nursing, S.R.N.—is comparable to a three-year diploma program in the States. Those who successfully complete this course of studies are Registered by the Nursing College of England and Wales: They are known as Sister Nurses.

The preferred background for this course is successful completion of Secondary school. In the past it has not always been possible to find enough women students who could meet this requirement. Until the time came when it would be possible, the Nurses' Board established an intensive one-year pre-nurses' program in connection with the government training college at Korle Bu, Accra. This program was to bridge the gap and make it possible for students with the necessary potentialities, but lacking opportunity for completion of secondary school, to be admitted into the S.R.N. program.

Qualified Registered Nurse is the Second Grade of Nurses in Ghana: Practically, the Qualified Registered Nurse receives somewhat less theory than the S.R.N., more in degree, than kind. As far as Nursing Arts or Practical Nursing is concerned she completes the same subject matter as the S.R.N. "Middle School Leaving Certificate" or a successful passing of Formal or Secondary School is the requirement to enter this course of studies.

There has been a remarkable increase in the number of girls who have been

Nurses preparing for classes, Berekum.

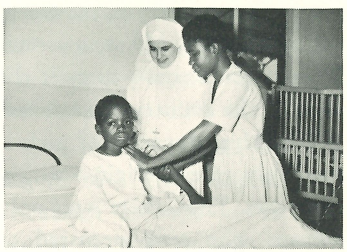
able to complete their Middle School course. One must try to appreciate what it means—to build a three-year nursing program onto a Middle School Leaving certificate — roughly equivalent (in school hours) to our junior high school.

During the last World War a number of African or Ghanaian soldiers joined the Army Medical Corps. Their interest in this type of training continued after they left the Army. Many of them completed their training and received their certificates as *Qualified Registered Nurses*. These male nurses trained, under the Sister tutors from England, formed an important nucleus of the pioneer registered nurses of Ghana. These Qualified Registered Male Nurses of Ghana, are forceful, vital leaders in the present picture of nursing in Ghana.

As Holy Family Hospital, Berekum, has the only unsubsidized Catholic Nurses' Training School in Ghana, how does it fit into the picture?

Actually, our students follow the same curriculum as that of the Government Schools in Kumasi and Accra. And they share the same aversion for classes that most student nurses do—preferring bedside nursing. They are especially eager for maternity or baby work, as is every young African woman.

After 18 months or at least 12 months as student (pupil) nurses the students take what is called a preliminary qualifying examination for the Nurses' Board. When they are successful with these examinations they work and study another 18 months or more and take final examinations.



Sister M. Annette helps a probie dress a patient's arm.

By and large, our students come from rural areas; their parents are intelligent and hard working, usually it is the mother who has made tremendous efforts to secure this formal education for her daughter, or it may be the mother's brother or the student's older brother who supplies the basic necessities.

Probably the mother herself does not speak English, even if she does, it would be unusual for it to be the language spoken in the home. This means that the student has a classroom knowledge of English. Spoken English is better than the written, but both lack appreciation

A young African student who will make a splendid nurse, Holy Family Hospital, Berekum, Ghana, W. Africa

IM GHANA

of concepts and ideas or idiom that only come with practical use.

Most of the girls are accustomed to hard physical work but not under the set discipline required in Nurses' Training. They are usually generous, cheerful, respectful and obedient. Often they are sensitive and because of lack of understanding of cultural values or the relative importance of events they can be hurt.

At home, naturally they eat according to their own customs. In a professional school they must become accustomed to eating "western style." It is not that we want to force western ways upon them, it is just something an educated African woman is supposed to know. It is difficult to change a lifetime of personal habits in a short time — especially such things as bathing, sleeping, eating, recreation. As the students themselves become accustomed to this it is easier for them to care for their patients, using proper facilities. Also in eating. One of the health paradoxes of Ghana is the availability of food, and the great amount of poor nutrition — but we often find the same problem here in the United States.

Our students come to us with their own accustomed eating habits. They are fussy about their food, and have little or no spirit of adventure in trying new foods. Most of them are good cooks in relation to the foods they like to eat. According to their custom they usually do not eat until about 9:00 or 9:30 a.m. Eating an early breakfast, before going on duty, is a real change for most of them. Unless they integrate these habits of good nutrition into their own daily diet they will have a very difficult time helping patients change their ways of eating.

It is wonderful to see how frequently they use their heads. The first time Doctor sends Mary Nyamekye, a probie, for a dressing tray she may return with it on top of her head moving gracefully along. An instrument jar, a lighted primus stove, a book or even a mattress — the temptation is always there to carry them on their heads! in perfect balance. A custom which cannot be included in the setup of a professional school. However, the habit is successfully broken when the probie gets her cap. This symbol of her profession takes priority!

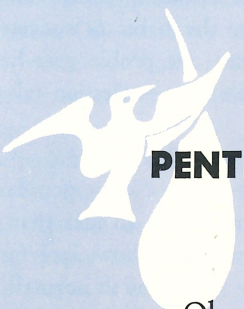
For recreation they love to sew — a hand sewing machine is very popular. Some of the women have an idea that a pedal machine will somehow interfere with their ability to give birth normally. The students' Ghanaian dresses are simple and very becoming. Occasionally, they like to wear modern western style dresses. Here, they could use some help

Sr. M. Patrick with a class of student nurses, Berekum, Ghana.

in individual styling — fit and color combinations would have to be according to their taste. This type of help is most important if they are to take their place with confidence and charm as educated Christian women of Africa — leaders who will set a good example.

Our task is to prepare nurses — the Syllabus is set out, cut and dry — all along the way there is the necessity of reinforcing the foundations, developing in our students a concept and conviction of their real dignity as Christian women. Here we must be careful not to distort or repress their natural spirit of giving, but to direct, and give it purpose. We would like to prepare Ghanaian Catholic Nurses who will be leaders in the field of Nursing. In each group, we feel there should be some who should be given the opportunity of some training or work outside their own country and thus gain a broader knowledge. This opportunity a number of nurses in the government training school already have been given.

IN GHANA



PENTECOST IS MISSION SUNDAY FOR THE SICK

Oh what a triumph it would be for the Church if it were possible to enroll under the banner of the mission apostolate all the Christians who suffer in the hospitals, in the sanatoriums, in the rest homes; if it were possible above all to make these places centres of spiritual support for the mission army; finally if it were possible to persuade the infirm to give their pain, accepted with love from the hands of God, for the missions.

Many Christians have the wrong idea that missionary assistance is carried out completely in the simple offering of material help. To such a way of thinking, the missionary problem is reduced to the level of just another human problem, whereas it is essentially a supernatural problem.

John XXIII.

CHANGING PATTERNS OF NURSING

in Pakistan

Sister M. Gabriel, B.S.N.

When we look at our nice new Pakistani graduate nurses, all trim in their white uniform and white shalwar and cap with the black band, we seldom think of all the hard work and trials that have gone into getting them ready for Graduation Day. Trials not only of those who have taught this particular group, but also of the many Sisters who have done the pioneering work in this field. On looking back through the old training school records in 1928 . . . . it is a sad situation . . . . the girls who came were from a very poor class and nearly everyone had to be dismissed for disobedience or just inability to do the work. Our pioneers in Holy Family Hospital, Rawalpindi, in those days were Sr. M. Laetitia and Sr. Agnes Marie—both as we know, were not to be daunted by any difficulties or obstacles.

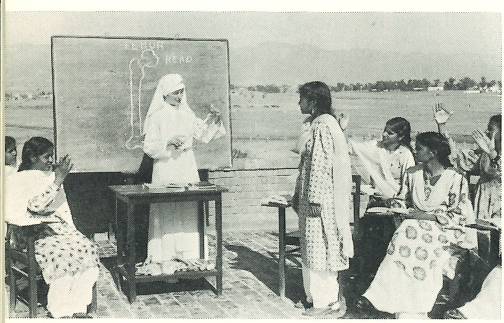
In 1930 the North India United Board of Examiners had approved the training school but the standards were still quite low . . . 6th class only was required and hence not much could be expected of that type of girl. Only Christian girls offered to do the work as both Hindus and Muslims were forbidden to do it due to many of their religious restrictions. The Christian girls came from the poorest classes for the most part, and were taught in the native language.

Later Sr. Margaret Mary took over the training school but things were still pretty discouraging until the first Bengali Sisters entered training in 1935. These were Associates of Mary from Bengal and two of them graduated in 1938 as the first real graduating class of nurses . . . . a full ten years after the Sisters had started taking students. After that we won't say it was smooth sailing but it was a good beginning in the right direction. Midwifery classes were started in 1936.

In 1940 Father Pinakatt from South India asked if he could send aspirants from Malabar who would eventually be Medical Mission Sisters. After this time until Partition a number of South Indian girls came to Rawalpindi for their training and later joined our own community in Kottayam. They became pioneers for our Indian Medical Mission Sisters and now are able to run two of their own hospitals in the South. Sr. M. Dolores had charge of the school from 1942 to 1948.

Other Sisters came from Bengal, Patna and Ajmere. Up to 1948 there were 48 graduates who were Sisters or aspirants and during this time only two lay nurses finished . . . one a Punjabi girl in 1943 and one a Bengali in 1947.

Sister M. Martin, R.N. with two Pakistani student nurses, Holy Family Hospital, Rawalpindi, West Pakistan.



Sister M. Kathleen giving anatomy class on the roof, Rawalpindi, West Pakistan.

Student nurses enjoying music for recreation, Rawalpindi.

In 1947 came the Partition of Pakistan and India with disastrous results as far as nursing in Pakistan was concerned. There was no longer any way of Sisters coming from Bengal or South India and local Punjabi girls did not have the education, or if they were Muslims, were not allowed to join nurses training. There were no graduates in 1950 and only 3 in 1951. As nearly all the graduates up to this time belonged to South India or West Bengal, Pakistan was left with hardly any nurses (200 for 80,000,000 people). It was like starting all over again as in 1928. These were what you might call the dark years. However, the government of Pakistan, realizing the desperate need for nurses encouraged Pakistani girls to take up nursing and the first class of Military nurses was begun in our hospital with Sr. M. Clare in charge of the school from 1948 to 1951. This group finished in 1952 and numbered nine, three of whom were Muslims . . . the first to graduate from our school. This was a red-letter day and gave the impetus to other Muslim girls to join nursing. After that time the classes have been about one-third Muslim, one-third Catholic and one-third Protestant . . . a very good mixture.

In 1952 the school was made a Grade-A School with recognition for male training. Sr. M. Kathleen was in charge of the nurses from 1951 to 1954. During this time more Punjabi girls came for training and things were finally getting settled in the pattern which is still present today. Eighth class was required but as the standard of English was so poor, it was a real battle to get a girl through training. It often served for some classic "classroom boners" that were often seen on papers. One nurse wrote that the treatment for a certain case was to "put hot complications over the bladder." Another said that "a tepid sponge is used to remove the circulation," and of course the spelling was purely phonetic and required an agile

Rabina, one of our graduate nurses, rides her bicycle on the hospital roof.

Sister M. Gabriel and student nurse with two sets of twins born on the same day, Rawalpindi, West Pakistan.

Mrs. Siddiqi, speaker at nurses' graduation with graduates and those who received their caps.

mind to figure it out. Much time had to be spent teaching English and going over and over the material which for one who knew the language would have been quite simple.

In 1955 when I was Sister-tutor, I was fortunate enough to have as first assistant Sister-tutor, one of our own graduates who had done this work, so at last we feel that some of the efforts that had been made for years are bearing fruit, when the Pakistani girls themselves can do some of the teaching. Later when Sr. M. Roberta replaced me, many more improvements were made . . . . a house mother for the nurses, improvements in the nurses quarters, classes in subjects not taught before and many more lectures. In 1958 Matric. passed (10th class) was required and considerably lessened the number of students who failed the exams and also gave the public a higher opinion of nursing. The block system of alternate class and duty blocks was begun in 1959.

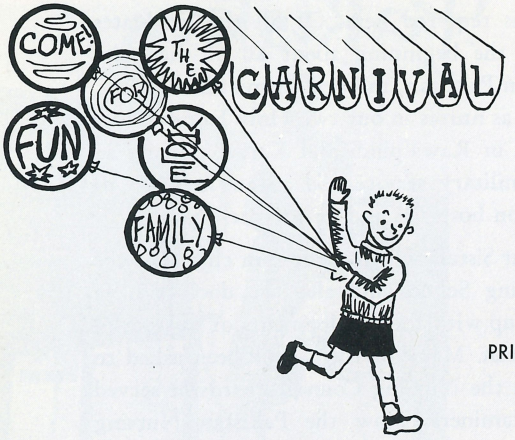
In all since 1938 there have been 128 graduate nurses who have finished their training in Rawalpindi. Of course this means that there were many more than that number of students as about only 55% of those who started training were able to finish. In this period 152 midwives were graduated, 28 of them Medical Mission Sisters. This is a course given after graduation for one year and is required here. Of all the graduates since the beginning about 80 of them are still in Pakistan, most of them still working, some as nurses in our two Holy Family Hospitals in Rawalpindi and Karachi, many in the military service and a few in Civil or Mission hospitals and on private duty.

Our Sisters who have been in charge of the Nursing School and also the doctors have kept up with the developments of nursing in Pakistan. Many of them have been asked to be on the Nursing Council Boards or served as examiners. Now the Pakistan Nursing

council is working on improving the curriculum and the status of nursing, to encourage a better type of girl to join nursing. Our Sisters will be right there with them to encourage them and do their part in improving the standards of nursing in Pakistan as they have in the past.

Our nurses who have graduated from Holy Family are everywhere much in demand as everyone knows that they have received good training. Here in Pakistan, a graduate nurse nearly always becomes a head nurse or a supervisor and is often asked to take full charge of the hospital nursing in some smaller hospitals even when still quite young. In technical ability they compare favorably with American nurses, many a scrub nurse has been first assistant to the Sister-doctor at an operation or has done her turn as Night Supervisor in our 200-bed Rawalpindi hospital and done it well.

Each one who has had a part in the nurses' training feels a thrill at seeing the graduating class, but the Sisters cannot sit back and rest on their laurels as much more work remains to be done . . . improving the techniques and skills of the nurses, giving more classes, encouraging them to take more responsibility, preparing girls for post-graduate study in Pakistan or abroad and helping them to realize their obligation to improve the health of their country, getting more girls to take up nursing, as the classes are still very small in comparison with the United States. At present there are 51 students in Holy Family Hospital Training School spread throughout the four years of training. So many more could be used, in a country that has only 800 registered nurses for 80 million people. A separate Nurses' Home is still a project for the future. So the scope for improvement is still very broad, but the Sisters really feel that they are contributing greatly to the advancement of a country which is aware of its problems and anxious to be able to solve them with their own trained people like our Pakistani nurses, who we hope will be able to train the Pakistani nurse of the future.



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Mariam, the Adibasi Nurse

Sister M. Jerome, B.S.N.

Sister M. Jerome

Mariam Toppo is a typical student nurse in our Mandar Holy Family Hospital in India. Like most of our Ouraon students she comes from one of the many villages in the great Chota Nagpur region now commonly referred to as Ranchi District. Over one-half of the Ouraon tribal peoples in the State of Bihar live in Ranchi District. Her family name is "Toppo." Like all the family names of the Ouraons it had its origin in the Fauna and the flora of her tribe's past habitats. Her family name or "totem" is taken from the Ouraon's name for a species of long-tailed birds. Each totem has its legend, such as that of the Kujur family. It is said that while an Ouraon slept under a Kujur plant, a flexible twig of the plant entwined round his body and protected him from molestation. Accordingly, that man took the Kujur plant for his totem and his descendants now form the men of the Kujur clan.

They believe that all the members of a particular totem have a common origin and that the totem exercises a protective influence on the members of that

totem. Likewise certain taboos must be observed in regard to the totem. Members of the Beck (salt) totem while not being forbidden salt altogether, must not take it in its pure form but only when dissolved in food. These taboos are no longer strictly observed, but are very deep seated and if Mariam were asked if any of the Christians in her village still observed them she would say, "Some may, but only out of respect."

Mariam like most of our Christian students from this area, was educated by the Ursuline Sisters. Her father is a master in the village school, where she received the first rudiments of her education. When she reached the 7th class her parents sent her to the Ursuline Girls' School some 30 miles away. This was her first time away from home, but she soon fell into the routine of the school, so well adapted to meet the needs of the *Adibasi* (aboriginal) girls. Each day began with Holy Mass during which were sung the familiar Ouraon and Hindi hymns which she learned as a child, plus new ones she had never heard before.

After Mass there was breakfast, followed by an hour of manual work either in the garden or in the school. Two hours a day are devoted to manual labor. Manual labor is the criterion by which an Ouraon girl's future in-laws will judge her. When a girl gets married, she goes to live in the house of her mother-in-law and if she works well her mother-in-law will be pleased with her, and all will be well. All Ouraon women are expected to help with the planting and harvesting of the rice, tend the children, herd the few oxen and goats, and carry the well water in clay pots on their heads.

One of the things that struck me most when I first came to India was the absence of truck gardens in the very heart of the farming district. The farmer usually plants only rice. The sisters teach the girls (most of whom will marry shortly after the 8th or 9th class) how to grow vegetables and even fruit trees so that they can raise them for their families and add some little variety and much needed vitamins to their rice and salt diet.

For the last three class (9th, 10th, and 11th) gardening is not a part of the curriculum. These girls are preparing to write Matriculation (the qualifying examination for all higher studies) and they are the ones who will go on for teaching or nursing, two of the main professions open to women in India today.

How has Mariam been prepared for nursing?. Mariam has the advantage of having educated parents. Formerly it was the usual thing for neither parent to have any education. Now-a-days many of the girls come from families where one or both of the parents have had some. What a difference this makes! On a visit to one of the girls' schools in this region, I happened to attend morning roll call of the students. As the students marched out, the Sisters

Nurses' home, former Quonset hut, Mandar, India.

Students discussing O.R. techniques.

pointed out to me the girls whose parents had some education. You could pick them out without being told. Their hair was neatly combed, their saries neat and clean, their whole appearance bespoke care and cleanliness.

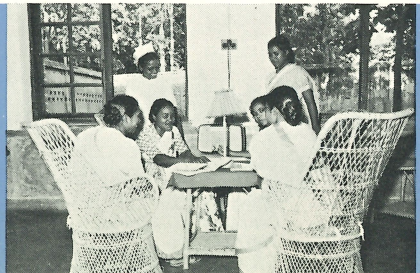
Group living at the nursing school is not a problem for the Ouraon Christian girls. Most of them have been boarders at school, at least in high school. Nor are they bothered by crowded quarters. At home they slept on the floor; in boarding school they spread out their sleeping roll on the floor of the large school hall and go soundly to sleep.

For most of them, however, coming into training means the donning of their first pair of shoes and the first month or so, the Dispensary is 'deluged' with sufferers from blistered feet. Out of respect shoes are never worn into church, but left at the doorway. For any heavy or quick work in the hospital, the first gesture of assistance is kicking off the sandals—then lift the bed or chair. Once in the O.R. the scrub nurse in breaking a tube of cat gut for the doctor, dropped some glass to the floor. As soon as the doctor had the suture she quietly slipped off one sandal, picked up the piece of glass between her toes, transferred it from the floor to the waste can.

The first big problem Mariam met in training was the language, but she has been meeting this since she first started school. As a child she first learned to speak in her mother tongue, Ouraon, but soon after she began to pick up Sadri words, the common language of the market in her area. This common market language is essential as there may be several tribes living in the same area, and even from village to village there are differences. When Mariam went to school she had to learn Hindi, the official language of her country and about the 5th or 6th class she began to study English. With the new stress on Hindi this English study may be delayed up to the seventh class. As most of the Sisters in the school are Belgian, she learned English with a Belgian accent and at first she found our American accent very confusing. This was a very difficult time for Mariam and many's the time she felt like giving up. Each day there was the repeated effort to understand what was going on in the English class and each day, the frustration. But then the day came when Nursing Arts began and she went on the floor for the first time, and was filled with fresh incentive—English was beginning to penetrate—she was beginning to understand.

The next six months was a very happy time for Mariam. She had the joy of her new found friends; of taking care of patients and each day there was Nursing Arts to look forward to, when new secrets of the wonderful workings of the human body were revealed to her. The clinical instructor was always there watching each new thing she did and she felt confident in her presence. It was a happy time for

Sister M. Jerome, B.S.N. giving class to Adibasi student nurses, Mandar.



Nurses enjoying recreation together.

her, enjoying the satisfaction of nursing without the responsibility—and culminating in the reception of the much prized cap.

The second year was difficult again. The first fervor had waned somewhat and now she had to begin to take responsibility. She made mistakes and was corrected, but she took corrections well. She had to learn the delicate balance between Doctor's order and the patient's desires. This was a very difficult thing for her to learn. Never before had she told an adult what to do, and much less a man. How often we hear the excuse, "Sister, the patient said he did not want it." Or "Sister, she refused it." To overcome this calls for long steady effort and guidance.

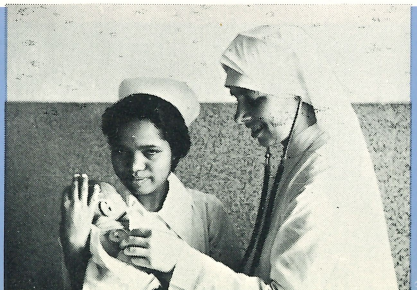
As the educational level of the students rises, more is asked of them. How much these advances in their educational level will affect their efficiency as Graduate Nurses is yet to be seen. Up to 1958 the majority of our Adibasi Graduates were Grade B nurses (for this only 9th class pass is required). Now they are all Grade A (Matriculation pass). For bedside nursing they are well prepared, in fact they make very good bedside nurses and operating room nurses also. In a mining hospital in this area the nursing is completely supervised in the women's section by our Adibasi graduates. As the cultural background improves and the whole general level of education rises, more and more, they will be taking positions of leadership in nursing.

Anyone who wants to work among these people must, while trying to raise the standards, constantly keep in mind that only two, or three, and in some cases only one, generation ago, their ancestors were still steeped in Animism and lived their lives in constant fear of offending some hidden force of evil believing all sickness to be due to some evil spirit. They had no knowledge of the modern concept of hygiene. Even now their simple mud homes where the floor serves as table, as bed and chair, have no mechanical devices. Consequently, when the girls come for training, they have no idea how even a simple door latch works, much less how to use medical equipment.

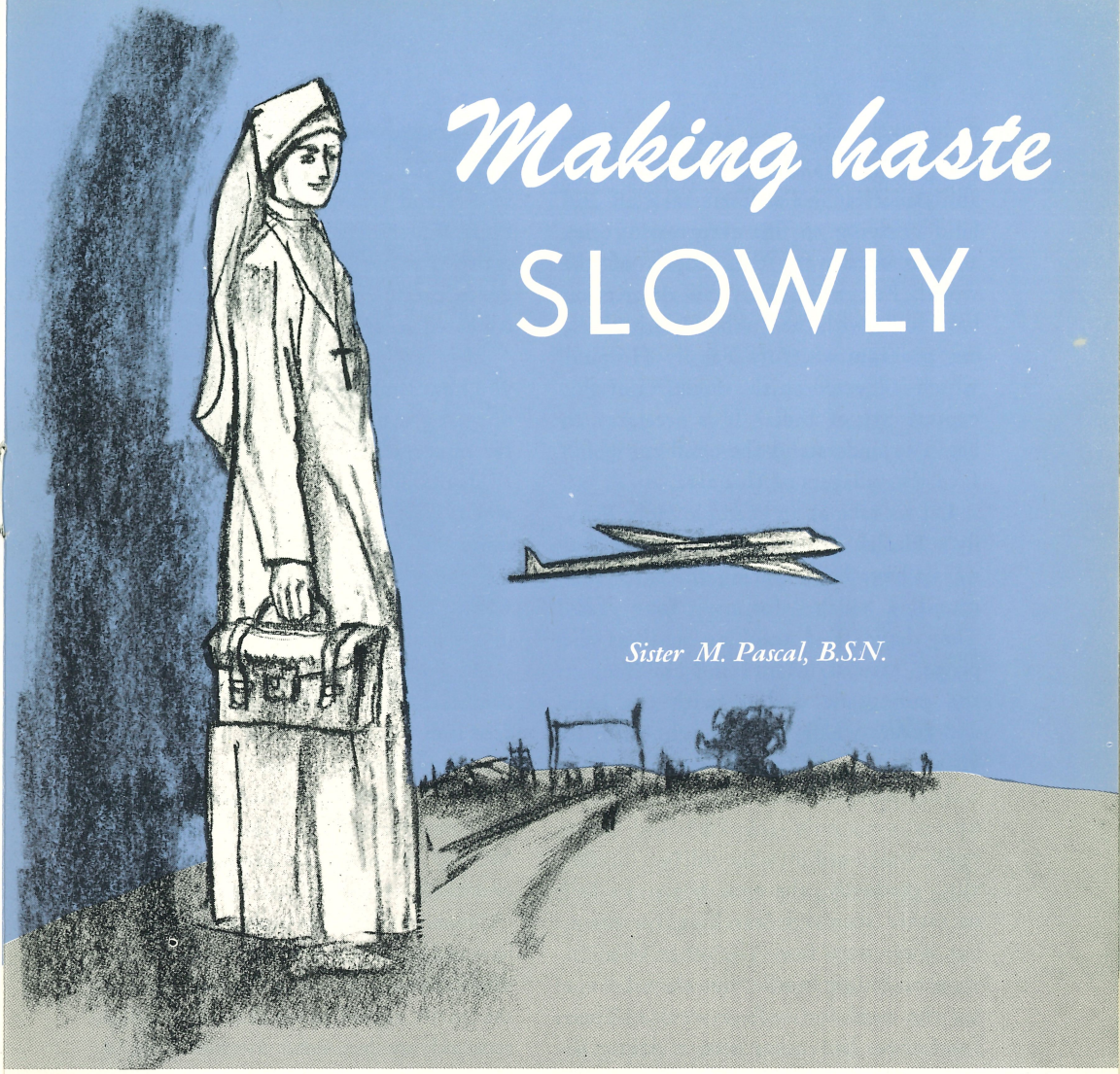
One who attempts to work with these Aboriginal girls without keeping these things in mind is in for a life of constant frustration and misses all the good in them. One must look to their generosity, their desire to learn, their simplicity (I have yet to find one who is sophisticated) and cheerfulness, their ability to put up with hardships an inconveniences; and if they know you really love them, they will do anything for you. If one begins with this positive outlook there is something to build on, in fact, the basic elements for nursing are there.

The future for the Adibasi nurse augurs well. A few have already proved their worth as good nurses. Others will follow and surpass them. We must not expect too much too soon. We must dig deep foundations.

Adibasi girls have proven themselves to be very good nurses.



Sr. Claude, M.D. chats with an Adibasi nurse, Holy Family, Hospital Mandar, India.



Making haste SLOWLY

Sister M. Pascal, B.S.N.

Delhi, India, is a city of contrasts. In the old Delhi area one finds the homes and shops of the people crowded in the shadows of the walls of past generations. These thick handmade stone walls and gates call to mind the fact that the Mogul Emperors reigned here hundreds of years ago. The crooked side lanes and narrow paths in this area have changed little since the days when turbaned horsemen rode out of the Kashmir or Ajmir gates of the city to war against any petty kings who dared to rise up against the mighty sovereign who ruled from the strong city of Delhi.

Just five minutes drive from this area is the other part of the city called New Delhi. Here the streets are broad and tree-lined and many of the shops are built along European lines. This is the area where East begins to meet West.

Twenty minutes drive from the New

Delhi area brings one to the large airport where the large British, Russian, and American jet airliners take off and land bringing to this evergrowing city a cross section of the peoples of the world. But what does this description have to do with the Public Health Nursing program of Holy Family Hospital which is located on the outskirts of this capital city of India? It is necessary to begin to understand the conflicts which face the villagers of this area.

Let us take as an example Holy Family's Health program. The Sisters and nurses have been visiting the three surrounding villages for over four years. They have tried teaching mothers the proper care of infants and children, at the same time dealing with the boils and fevers which first brought them to visit a particular family.

For several years the Sisters and nurses were only tolerated and never really welcomed into the village. Gradually, gradually, the sick began to call us rather than our searching for them, but these were few. The other villagers were no longer hostile, but they did not see the need for such a service. Their forefathers had never seen a doctor or nurse, so why should they or their families trust such new and strange ideas.

Still, the Sisters and students persisted in their daily visits to the villages. After three years of visiting the mud hut quarters of the sweepers or the brick houses of the farmers or shop keepers, people began to call for a nurse midwife to come to deliver their babies. Again, these were few in number, but then, India has one of the oldest civilizations and the uneducated do not change their ways rapidly. Along these years there have been joys and sorrows, advances and setbacks. Just when one thinks that the people are beginning to understand the necessity of health care there will come a series of cases that will prove that we still have a long way to go to catch up with the jet age of the educated in the city.

Here are a few cases that will show you how some of our people are weighed down by custom and consequently suffer unnecessarily.

Shanti Devi was expecting a baby when we first met her on our home visits. She had three other small children, all under six years of age. Her husband was a farmer and could call a small plot some 30 x 40 feet his farm. Shanti was anemic and undernourished, as were the rest of her family. We offered her free iron tablets and milk to help build her hemoglobin up to at least 50% before the baby came, but she refused, and also refused to take wheat from NCWC or milk and vitamins for the children.

None the less we continued to visit her and tried to make her change her mind. After a month of patient trying, she finally agreed to see that the children received much needed vitamin pills. A few days later her husband met us and returned the pills and said that the mother-in-law and he were against all modern help. "Ram" would look after his wife and children.

A few weeks later we were in the area so we again stopped by the hut. The woman had had a baby boy just a few days before and it had died a few hours after birth.

The temperature during this month of summer ranged between 100°-110° every day and noticing that the mother looked extremely dehydrated we encouraged her to drink plenty of fluids

Ramala Wati, who had the courage to come to the hospital despite mother-in-law's opposition. Sr. Charles, New Delhi, India.

as well as eat a few chapatties and curry as she appeared so weak. Again we met with a "no" for it was the custom of her husband's family that a woman should fast for ten days after delivery and take only sips of water. This was the first and only time I had ever heard of this custom, but the woman and her family held to it.

The next week when we were in the compound we were informed that she had died. The husband said that Ram had taken her away—and only four miles from this village some of the most brilliant minds of Indian doctors are working and experimenting, pushing forward the medical frontiers in India.

On the other hand we were given hope by those who break with taboos and bravely face the mystery of modern medicine.

Ramala Wati's old mother called us to their modest little hut. Her daughter was in acute pain and was hemorrhaging. They asked for us to care for her on the spot. After examining the patient, there was only one thing to do—take her to the hospital some 15 minutes away from the village. We told the mother that the Sister doctor would have to operate immediately.

A family council was held, as usually is the case, and the mother-in-law said "no." The argument went back and forth for a while and finally Ramal Wati, and I admired her courage, told the mother-in-law she was going any way!

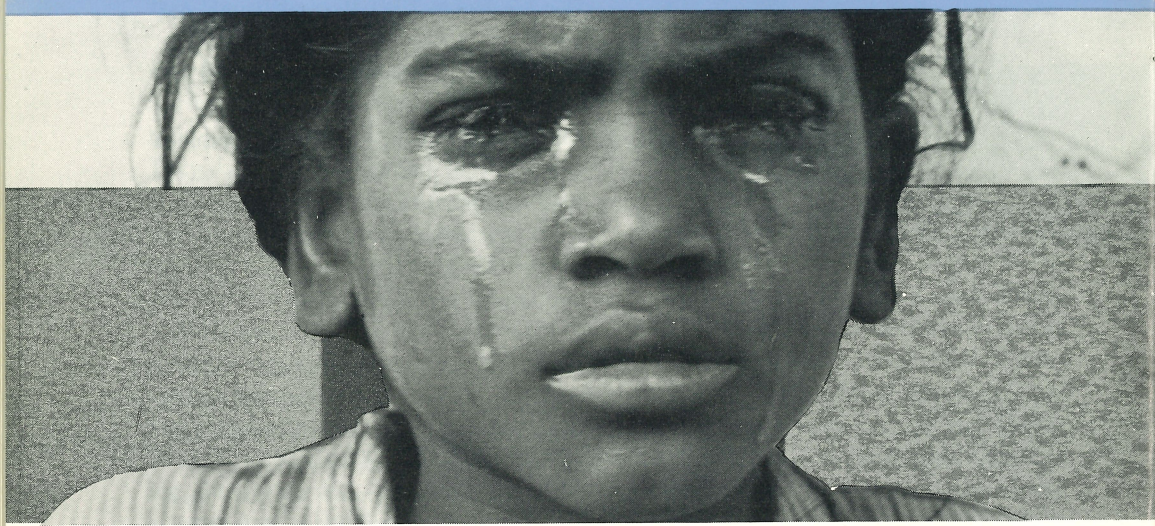
Without further ado we carried her out of the house to our bicycle, sat her on the luggage rack and bounced over the ruts and open drains out to the road which led to Holy Family Hospital. In a matter of a few minutes after arrival she was in surgery and had an uneventful recovery.

Now she comes to the hospital for check ups and brings various relatives with her. They too, after the initial fright of going into a big hospital, now see the value of medical care.

The Health Program? We are "making haste slowly." One goal has been reached, for recently the elders of the village have given us a room where we can have patients come to us for examination and minor medical care. At the end of the morning we usually walk or cycle back to the hospital with one or more patients who need a doctor's care and hospitalization.

As the jets roar overhead, and the fancy Buicks and Plymouths drive down the road between our four villages, we will continue to work in huts without running water or sanitation, to walk down the dusty fly-covered lanes, not that the jet age may come, but that in each of these hearts His kingdom may come.

THE BLIND



"Come all you who are blind and see." This is literally what has happened here in our Kurji Holy Family Hospital, in India, daily, since the arrival of Dr. William Caccamise on November 20th, 1959, Rochester, N.Y. Dr. Caccamise was in Patna in 1951 and he came back this year again. His work in the past three months has been remarkable. And as one of the many newspaper articles stated "is helping to bring America and India closer together."

The opportunities here for eye surgery are very great, as India is the land of eye diseases — cataracts, glaucoma, trachoma, vitamin deficiencies and blindness from all causes: infections, smallpox, optic nerve degeneration, meningitis, etc.

Weekly, hundreds of patients were seen in the out-patient department. They came from all four corners of India, one patient even flew in from Assam to visit our eye clinic.

Patients had to be limited to a hundred a day, as this was as many as Doctor could possibly see in one

SEE

Sister M. Bernardine, R.N.

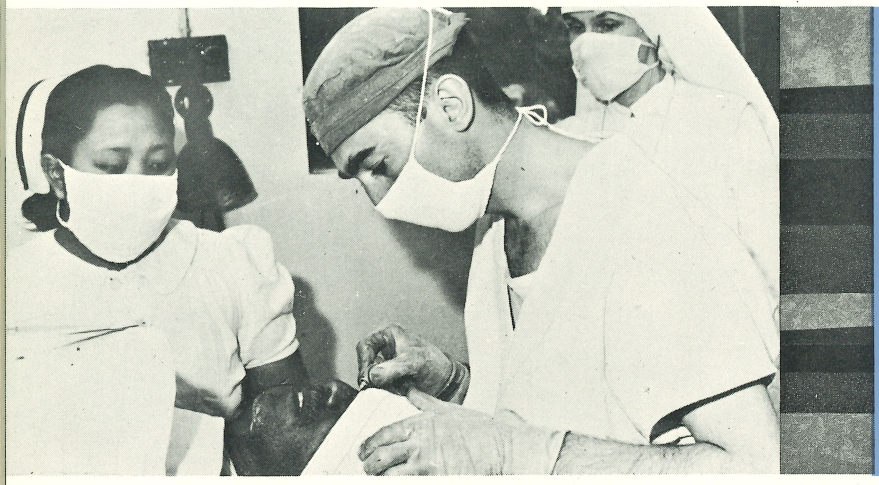
morning. Some patients came back two to three times before they could be seen —as first come, first admission. Some patients got wise and simply moved bed and belongings to our out-patient department lawn all night, to be sure to be there early enough for the morning quota. At 9:00 A.M. already, one could hear a great commotion in O.P.D. —the quota had been reached and patients were pushing and begging our clerk to be admitted. One day the crowd was so great a small boy who was trying to get a closer look at Barno our admitting clerk, was pushed up against the edge of the desk. Sister Carmella just rescued him from asphyxiation in time.

Because of the great number of out-patients, surgery had to be limited to afternoon, and clinic in the morning. Some days Doctor Caccamise was in the clinic until ten minutes before the first operation case, making sure all the poor had been seen. Everyone was treated equally—the rich and poor stood in the long line awaiting his turn to be called. Daily new and rare eye cases were seen

mingled with the more familiar ones. In one day so many patients for surgery were admitted that it would take a week to operate on that many. Doctor Caccamise declared that the ratio was "one patient, one cataract"—while in the states about every 250th had a cataract.

The eye department not only filled the eye wards, but soon took over every spare bed in the hospital.

Since you have not had the joy of working with Doctor Caccamise as I have, I will introduce some of our patients to you. First, there is Sham Bihari, who was admitted here on January 11th, with "eye trouble." Sham is 16 years old and lives in Dinapore, a nearby village. Eight years ago he and his ten year old sister lost their parents, so that they are now living with an uncle in a very poor environment. It was hard for Sham's uncle to take in these children as it meant two more mouths to feed in an already semi-starved home. When Sham was six years old he had smallpox. One of the very serious complications of smallpox is blindness resulting from leucoma or a white dense scar on the cornea. Due to lack of care during the disease, poor hygiene and lack of education, Sham's right eye was completely ruined. It had atrophied far back into his skull. The disease also left an adherent leucoma (corneal scar) in the left eye which gave him very poor sight. In fact the only real things he could identify were light perceptions and large images. After that the family did take him to the General Hospital, but he was told to come back in a few years as he was too young for treatment. Needless to say he never went back and that was ten years ago.



Dr. William Caccamise of Rochester, N. Y., doing eye surgery in Holy Family Hospital, Kurji, India. Thousands came from all over India.

Sham, being of age, soon had to go out to earn his daily bread. Handicapped as he was, he gathered leaves and ropes and sold them in the bazar. This he did for the past year. It was decided that an optical Iridectomy would help to restore at least some of the iris to permit light to penetrate to the retina.

This operation was successful in providing greater scope to his vision. More

vision could be restored if a part of that leucoma could be removed and replaced by a healthy corneal graft.

On January 17th a pair of eyes, donated by the Rochester Eye Bank—flown 9,800 miles reached us here in Patna. It was a day of great excitement for everyone here at Kurji Holy Family Hospital. The operating room was immediately prepared for the transplants—Sham Bihar being one of the lucky patients, (hundreds of patients have visited our clinic with corneal scars), was to receive one of the two corneas. The operation was a success. The day before his discharge we took him out to the garden and he delightfully identified the colors of the brilliant colored flowers for us.

Sham Bihari gazing in wonder at flowers, after receiving sight from corneal transplant operation. Sr. Bernardine to left. Sr. Betrand and Sr. Carmella to right.

Christina is our second corneal transplant patient. She is a Ranchi girl but had been living in Kurseong with one of her sisters since the death of her mother at the age of 12 years. She is employed in household duty by the Sisters, Daughters of the Cross, and was sent to us by them for surgery. They were very interested in Christina's eye condition and had sent her to the Calcutta Medical College and one of the Kurseong Hospitals for treatment, but medical treatment was unsuccessful.

The only information Christina could give us about the corneal scar in the right eye, was that at the age of six she had a great deal of pain in the eye, which was not relieved by medication. Christina was terribly frightened and did not realize what a marvelous opportunity it was to have a corneal transplant. She immediately left and traveled the two days journey back to Kurseong. Sister Leonie, M.D. heard this and sent a telegram to the Sisters asking them to send her back to Patna.

Several days later her operation was performed. The success of her operation was equal to Sham Bihari's, although perhaps his was more dramatic, as he was almost totally blind, while Christina had a good left eye.

After hearing about these two transplants, people flocked in from all over India, asking Dr. Caccamise to give

them an eye. Blind beggars came begging for a new eye. They did not realize that only the cornea of the donor's eye is used and they wanted the whole 'eye' in replacement of their own blind ones. A couple of parents even wrote in and asked Doctor if he could take out one of their eyes for the sake of their blind children.

One of our favorite patients was Sheo Janam Pd. Sheo is 12 years old and was totally blind from cataracts since he was nine. He is from a village and very poor. Sheo attended school until one day he got a good beating from the master, and decided it was safer to work at home in the fields. Here he worked until he became totally blind—a year ago. Several home treatments were carried out then he was taken to the village doctor, who could not do anything for his blindness. It must have been very difficult for Sheo to accept his blindness after having seen the beauty of the sunrise and sunsets, and now only to feel its scorching heat.

Sheo had two successful operations thirteen days apart. Vitreous humor was lost in both eyes, but was replaced by humor donated by the Rochester Eye Bank.

Ashok Kumar is also one of our prize patients. He was only two years old and had bilateral congenital cataracts. A new enzyme, alpha-chymotrypsin, obtained from the pancreas of calves has made it possible to remove cataracts on eyes of young children. Even now, since the enzyme is so new, it is advised only for those over 20 years old, as the zonule, a suspensary ligament attaching the crystalline lens to the vitreous is very strongly attached in the young. The purpose of this enzyme is to dissolve this ligament but the younger the patient, the harder it is to dissolve. Perhaps Ashok is the youngest child in the world, or at least in India, to have a successful intra-capsular cataract extraction *without* the loss of vitreous. Since then Dr. Caccamise has performed the operation on a 10 year old girl and a nineteen year old boy. The rest of our patients ranged from 20 to 90 years!

A few days ago I walked through the ward and was extremely amused at one little old man. He was sitting cross-legged on his bed and enjoying everything going by. What made him so funny was his glasses. Ten years ago he had a cataract operation and had received ten plus ten glasses. He was still wearing the very same pair. They were broken at the bridge over the nose, and a piece of leather strip was holding them together. The two lenses met together at the center and sat midway down his nose. If he looked up, or to the right or left, he saw either over, or on the side of his glasses. I could not help but ask him what happened to his glasses, and he very unconcernedly said '*Toote Gaya*' (broken) with a big smile on his face. Broken or not he owned a pair of glasses, which was more than most people could boast of. After his cataract operation he proudly sported a new pair of plus 10 glasses. Glasses were given to all our cataract patients free of charge. This was made possible through a donation from friends in the States.

We of Holy Family Hospital are very grateful to Dr. Caccamise, and to the Rochester Eye Bank not only for helping to restore Sheo's vision, but also for the corneas they have sent. Dr. Caccamise, incidently, left a wife and four children at home to join us here for a few months. We are looking forward to having him come again in the future.

MISSION BOOKS

Sister M. Fabian, B. A.

ARCTIC WINGS, by William Leising, O.M.I. Doubleday, 1959. 335 pp. $4.95.

The frozen land of the Arctic is the setting for most of this stirring biography of an unusual missionary, a "flying" priest. The Northland apostolate is not easy, with vast empty stretches of barrenness, the long, unbelievably cold winters, the days without sun, the isolation of being miles from the next missionary. When a plane was donated to the mission, Fr. Leising learned to fly, and began an adventuresome and highly valuable contribution to the work. Flying in supplies, food, personnel, and even school children to the various missions, the "flying missionary" met with many an adventure, filled many a need. Another "better than fiction" glance into the world of the missions, "*Arctic Wings*" will be enjoyed by young and old alike.

VILLAGE LIFE IN NORTHERN INDIA, by Oscar Lewis. University of Illinois Press, 1958. 384 pp. illus. $7.50.

A scholarly, well documented and careful work, this will probably not reach a large number of people, but will be a "must" for those who proclaim an interest in modern India.

The study was made as part of the Community Development Project of Delhi State. One village, Rampur, was chosen for a year's intensive study. The great diversity of life in India makes it imperative to point out that this is a study of one segment of Indian life, viewed under many aspects.

Included are many interesting ideas and points, such as, a discussion of the jajmani system of service, for service in the economic realm; also, a poll of villagers' ideas concerning the cause of disease, the results showing a mixture of common sense observation, folklore, and some medical knowledge.

A valuable book, it will add much to the growing literature of community development. It has achieved its purpose to make a "contribution to our understanding of peasant life in contemporary India."

A MAN OF GOD, by Clifford J. King, S.V.D. Divine Word Publications, 1958. 144 pp. illus. $.50.

This small pamphlet introduces us to a big man, Father Joseph Freinademetz, pioneer Divine Word Missionary in China.

Starting with his early life, education and entry into the newly founded Divine Word Society, Father King gradually unfolds the unique and inspiring story of the Tyrolean boy who became an outstanding missionary in China. A wonderful life, filled with love and sacrifice, adventure of the highest kind, devotion and loyalty.

It is to be hoped that this little pamphlet will be the first step toward a full length biography in English of a man who deserves to be known more.

NEWS FROM

AFRICA Who's Who?

Mommy had just finished taking three of her four children to see the doctor. Their names were Salifu, Isidu, Walidu and Lalifu—and now they were in front of the dispensary window waiting for their medicines. In age, height and coloring they were very much the same, the oldest being about seven years old. Their charts and faces were before me, but just try to identify them.

"Salifu Lagos," said I, and Mommy patted one on the head. I pushed two bottles before her and explained when and how the worm medicine should be taken and the expected results—one finished.

"Isidu Lagos," the name on the next chart. Mommy smiled and patted *Salifu* on the head. "No Mommy, not Salifu, Isidu," but with the same persistence the same child was thumped on the head. "Be prudent," I whispered to myself and withdrew previous given medicines and instructions from Salifu and repeated them over again for Isidu.

"Walidu Lagos," and a three-year old child is pushed before me. "Mommy, rub this medicine on Walidu's skin wherever the scabies can be seen and give him one of these little pills to take four times a day."

Last, but not least where is little Lalifu? I was sure Mommy was playing favorites when Salifu received the nod, or was it Walidu, but for all I know it may have been Isidu. With this, I withdrew rubbing medicine, drinking medicine and pills and decided to start all over again. I could see in my mind's eye the worm medicine being rubbed on, and the drinking medicine being put into the eyes, and nobody taking the proper medication. With about 100 people standing by and each one trying to help me by asking, "Who is Salifu" and "Mommy, point out Walidu for Sister," we were getting nowhere fast. What seemed to be the only reasonable thing at the moment was done—drinking medicine, rubbing medicine and pills, Salifu, Walidu, Isidu, Lalifu and Mommy were moved to a free corner and with the help of one of the dispensary boys, proper identification was made, and medicines dispensed. Time out to study Twi!

SISTER M. MARTINA, R.N., *Holy Family Hospital, Berekum, Ghana, W. Africa*

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OUR HOUSES

INDIA Whose Job Is It?

The other day a flock of sheep and goats passed by with five shepherd boys guarding the flocks—a joy to the eyes, as the terrain is biblical to say the least—rocky, low hillocks, dry parched land, hungry herds, so I approached one of the shepherds and said, "Not much grass this time of the year. The rain is late. I wonder where it is."

Then came the homily—pointing to the heavens—"He has to give the rain. Grass won't grow without rain." Looking me straight in the eye, as he leaned forward on his staff, he almost knocked me over (Poetic license) with the application: "*And you're the ones whose job it is to ask Him for it!* But you need to ask a little harder." "Yes Sir," I said and turned on my heels, wondering when the last time was I had prayed earnestly for rain for the herdsmen and their flocks; the rice sowers and their rice; the cotton planters and their cotton, the sugar growers and their sugar cane.

Sr. M. David, R.N.
Poona Novitiate, India

PAKISTAN Fast Cure

Recently I had a patient who wanted to go home before he was cured. After all if you can't cure a person in a week, what good are you? His reason was—he wanted to see his mother, age 140! Of course no one really knows their age. The women will calmly tell you they are 25 and their oldest child is 20.

Occasionally, we have a Pathan patient from the northwest frontier region. They have splendid physiques, often six feet tall, and are supposed to be very fierce. One of them, 60 years old, was told by the doctor to have his blood tested. I'm sure he would not be afraid to meet a tiger single-handed, but he sent his 16 year old son to meet Sister Joan's needle and syringe.

Sister M. Christine, M.D., *Holy Family Hospital, Dacca, E. Pakistan*

Rawalpindi, West Pakistan. U.S. Ambassador and Consul visit Holy Family Hospital. (left to right) Srs. M. Roberta, M. Christopher, M. Gemma, M. Julia, M. Elise, M. Pierre, Mr. and Mrs. William M. Rountree (Ambassador) and Mr. Andrew Corry, U.S. Consul General in Pakistan.

PAKISTAN Cooperation

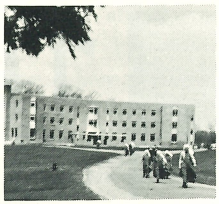
We had such a sick girl here . . . 12 years old. Bleeding, (Purpura) . . . It was nip and tuck . . . only Sister Regis' untiring efforts, plus the prayers of many, pulled her through . . . An ad was put in the papers asking for blood donors . . . also Radio Pakistan broadcast appealed . . . it was good to see the response. In all she had 22 transfusions. Catholics, Protestants, Hindus, Parses and Muslims were praying for her . . . You may be sure we did our share, and Sr. M. Joachim was working at a terrific rate of speed with her laboratory staff. One day about 200 donors came to be typed. Even some American sailors came. People came from all over. Finally, Sr. Regis, M.D. operated and took out the girl's spleen. The situation still looked hopeless for about three or four days more . . . then she improved and went home a couple days ago . . . God is good!

SISTER M. DOLORES, B.S.N., *Holy Family Hospital, Karachi, W. Pakistan*

Top: Sister M. Regis, M.D. with two friends — refugee children. Karachi, West Pakistan.

Bottom: Judibana, Venezuela. Triplets born at Sagrada Familia Hospital. Sr. M. Jeanne, and mother of triplets.

Correction: March-April issue. Sr. M. F. Rose Clare Neelankavil, Trichur, India, made final *vows in Patna, India, on February* 11, 1960.



PHILADELPHIA **Moving Day**

WE THANK YOU

Bright and early on the morning of March 31 the long awaited move to the new novitiate building began. The Postulants led the "pilgrimage," being the first to load the two large trucks lent for the occasion with their furniture and belongings. By the afternoon they were completely and safely transported to their new home, so the novices began to load the scores of boxes which they had been packing for days onto the trucks and to unload them at the other end. The long dreaded feat of emptying out the two large attics filled with "heirlooms" was actually accomplished in the process! The next day the beds and other furniture were moved over and set up, and by evening forty-two exhausted but relieved novices located their bedding and dropped into bed in their lovely new dormitories.

All went very smoothly, thank God. Even the rain which threatened all of the first day accommodatingly fell only at convenient intervals—a fitting tribute to the earnestness of novice and postulant prayers.

By now most of the boxes are unpacked and things are getting back to normal again; it is luxury to have so much space. Even the experience of finding yourself in a closet when you thought you were opening the door to your room, or of landing in the right room but the wrong floor, is becoming a thing of the past. The new noises, too, are losing their power to make us jump up in bed wondering what bell we missed. Many of the rooms are still empty for lack of suitable furniture, but all in all, we are settling down nicely.

The new chapel is beautiful. The altar and other furnishings are still temporary ones right now.

Our prayers on the day of our first Mass were certainly prayers of thanksgiving to God for all His benefits, and we asked Him to bless all those who have made the new building possible.

SISTER M. BENET, M.A.

MAY SHE REST IN PEACE

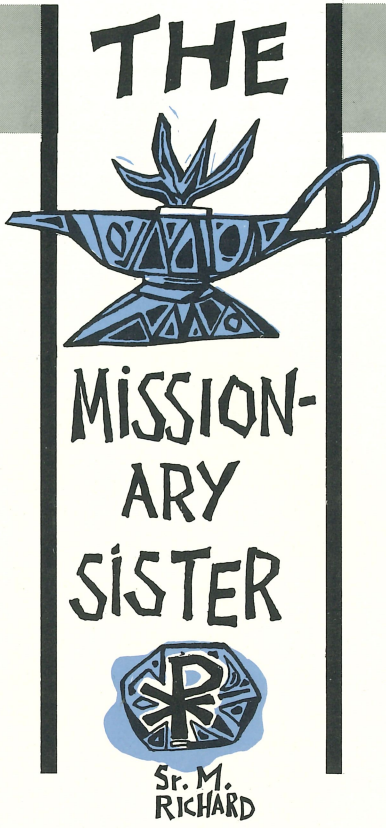
On Easter Sunday a cable was received at Rome from Mpendzwa, Belgian Congo, that Sister M. Jacinta Pouwels one of our Medical Mission Sisters of the Dutch Province died there on Easter Saturday. Sr. Jacinta, who was only 36 years old, was the Superior of the pioneer Congo Mission and also a nurse and midwife.

"The missionary work of the Church itself has been, for a long time now, almost inconceivable without the participation of the Sisters.

Without their collaboration the Church would have had to renounce much of its progress and surrender many positions gained at the cost of hard work." . . . Piux XII

Everyone, everywhere, is in some way the concern of a missionary Sister. And why is this? Because in some measure she has understood what Augustine said so many years ago: "If you want to love Christ, spread your charity all over the earth for the members of Christ are all over the earth."

The missionary Sister *does want* to love Christ, the whole Christ, His Mystical Body with all its members. She is very truly, a "daughter of the Church." She knows that her thoughts, her horizons must go beyond the boundaries of nationalities and reach around the world to encompass all. It becomes important to her, a matter of concern, that there are places where the Church is not yet established, that there are people, thousands and thousands of individuals for whom Christ died and for whom Christ and His saving death remain a secret. The missionary Sister makes her own, the words of Pope Pius XII: "We could say that nothing of what concerns Our Mother the Church is or can be extraneous to the Christian. In the same manner his faith is the faith of the entire Church, his supernatural life the life of the whole Church, the joys and anxieties of the Church will be his joys and anxieties, the universal perspectives of the Church will be the normal perspectives of his Christian life."



There are an estimated 20 thousand Sisters serving in the foreign missions. This is a cause of wonder to some. Why, they ask, should a young woman wish to journey to a far country, live among those whose climate and culture and language and customs are so different from her own? Why should she spend a lifetime serving people who never asked for her care and may not be grateful when they receive it? Why should she desire this so sincerely, so ardently.

This matter which puzzles so many, seems so clear, so normal, so logical to a missionary Sister. To her, the case is simple: if you love someone you try to give them what they most desire; if you love Christ, you know He desires

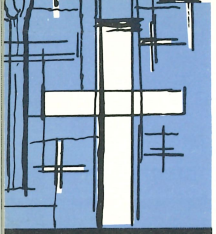
that all men come to know and love Him. He desires it so much. He died for it. But millions for whom Christ was crucified do not know Him. The impact of this statement brings with it a desire, an urgency, a force that motivates a missionary Sister to find a way, to play a part in the great work of extending Christ's kingdom, making Him known and loved by more and more and more. Pope Pius XII calls this charity of a missionary Sister . . . "industrious Charity." It is inventive, it finds very practical ways of introducing Christ to those who have never met Him. She goes where the need is greatest. This is part of her vocation.

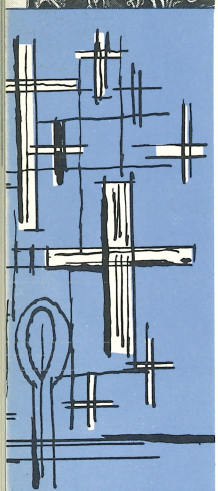
The missionary Sister must be "sister" to the world. She must pray to the Father in place of those who do not acknowledge that they are His children; she must offer sacrifices in their stead, she must mirror in her own person, by her very presence, something of the One she is trying to imitate and make known and cause to be loved. Her life and her prayer and her actions, must reflect her likeness to her Brother Christ. She is a witness and she lives among those who need to learn the Truth. She is a religious woman and she brings all the sensitiveness, the motherly affection and solicitude of her womanliness to her care of a sick child, a hungry neighbor, a homeless man. She is a disciple of Christ and she must love and sympathize and serve all men. She is an instrument in God's hands, and in the "folly" of His wisdom, she has been given a role to play in the mystery of the redemption of the world. It is this joyous message of salvation, this knowledge that Christ died for all men that must filter down through the centuries into the ears of every generation passing from man to man and woman to woman until the end of time. This is what Pius XII calls: "sweeping Christian Charity which transcends all warring camps, all national frontiers, all territories of the earth and expanses of the oceans."

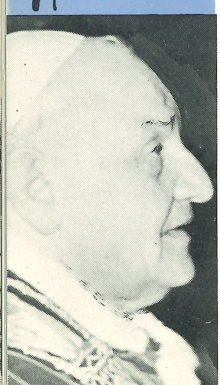
"Is not this zeal for the glory of God in a heart burning with love for its brothers, the highest form of missionary zeal? . . ."

Please pray for our benefactors recently deceased: **R. I. P.**

Rev. Thomas L. Carroll, Philadelphia, Pa.
Rev. George T. Concannon, Philadelphia, Pa.
Rev. Walter K. Conway, C.S.C., Elgin, Illinois
Rev. James Martin, C.S.C., Dacca, E. Pakistan
Rev. James A. Gerstbauer, Fort Wayne, Ind.
Mother Mary Gregory, O.P., Philadelphia, Pa.
Sister M. Florence Cecilia, S.N.D., Philadelphia, Pa.
Mr. George Allman, Norman, Oklahoma
Mrs. L. G. Conley, Philadelphia, Pa.
Mrs. M. Creer, Milwaukee, Wisconsin
Mr. Henry DeZutter, Chicago, Illinois
Mr. Frank Eschen, St. Louis, Missouri
(Founder of St. Louis branch of Men of Medical Missions)
Mrs. Irma Geiller, Philadelphia, Pa.
Albert S. Gray, M.D., West Hartford, Conn.
(Father of Sr. M. Luke, S.C.M.M.)
Mrs. Mary Hinkley, New Hyde Park, L.I., N.Y.
Miss Mary Kernan, Washington, D.C.
Mrs. C. C. Kriemler, Redwood City, California
Miss Margaret Morrissey, Philadelphia, Pa.
Mrs. Regina Sanford, Fremont, Ohio
(Mother of Sister M. Leo, S.C.M.M.)
Mrs. Ellen Wedemeyer, Jersey City, N.J.
Mr. E. Kenneth Williams, Jamaica Estates, N.Y.
Miss Anne C. Youell, Philadelphia, Pa.







THE ECUMENICAL COUNCIL

UNITY IN DIVERSITY

SISTER M. CUTHBERT, M. A.

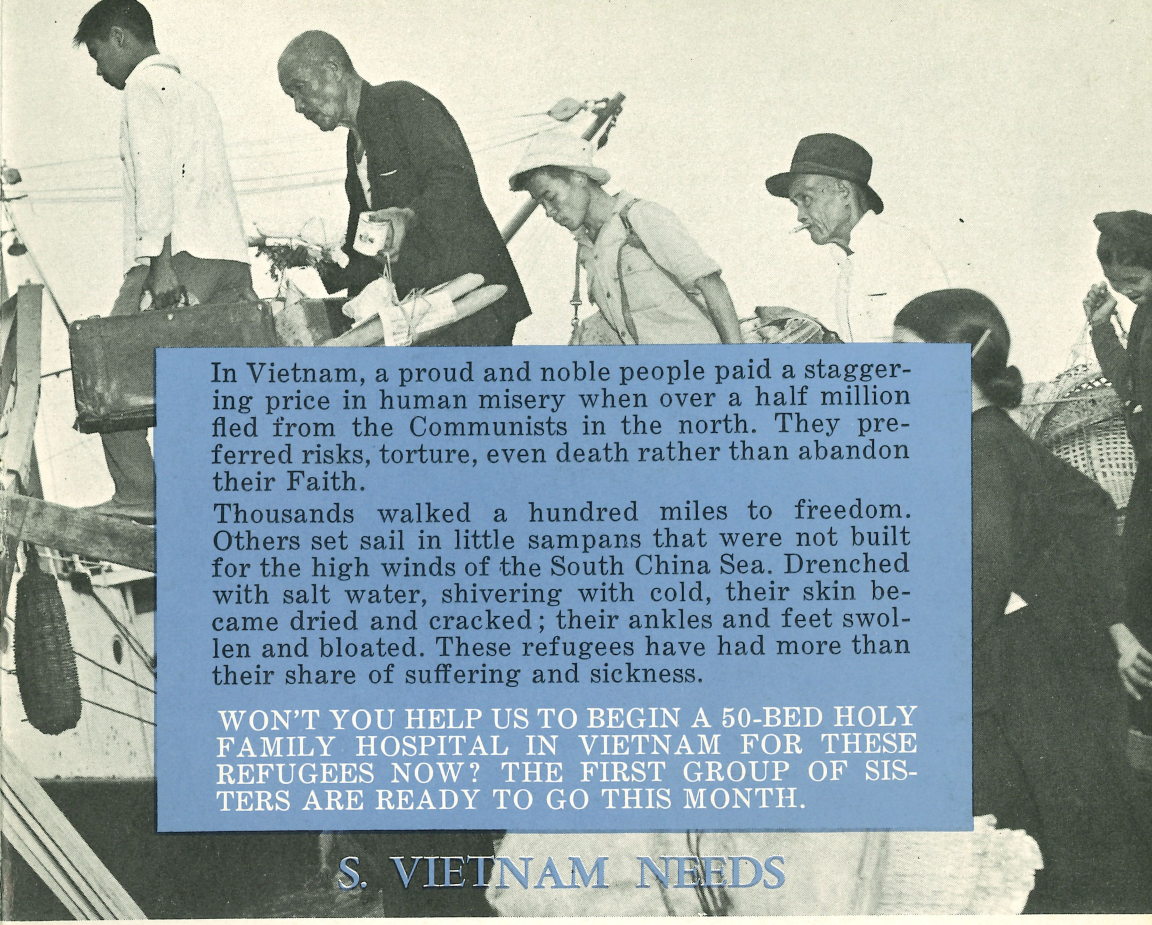
"Unity in Diversity" is the slogan of independent Indonesia and finds its echo in India. Yet long before either of them thought of it this principle already belonged to the Church.

Today more than ever unity in diversity is the pattern of holiness in the Church. She is one because each people and culture brings its own particular genius and talents to the work of the Church which is the redemption of the world. It is because the various groups have different natural talents to offer that they are dependent on one another's cooperation.

This is most evident in the variety of Rites found among Christians who are in union with Rome and therefore truly Catholic. It has been said that the genius of the Roman Rite, the one to which most of us belong, is the changing Proper of the Mass which gives a new apostolic inspiration for each day in a slightly different context each year as the liturgical and sanctoral cycles revolve each in its own orbit.

The Catholics of Eastern Rites are relatively few, perhaps 10 million, compared with about 400 million Roman Rite Catholics. Yet the Eastern Rites are important for their powerful expression of the spiritual aspirations of other cultures; the profound reverence and wonder of the Byzantine liturgy, the African love of rhythm as an expression of social solidarity in the old Coptic liturgy of Ethiopia, and the use of Our Lord's own language as the sacred language of the Syriac Rites.

The Eastern Rites are important apostolically because more than 140 million Dissidents share these Rites with the Catholics. Submission to Rome is not such a problem if they can keep their accustomed ways of worship. Therefore Eastern Rite Catholics are the best apostles for reunion of these Dissident groups. At present their main obstacle to apostolic work is lack of priests. A true work for reunion is to pray for vocations to the priesthood in the Eastern Rites.



In Vietnam, a proud and noble people paid a staggering price in human misery when over a half million fled from the Communists in the north. They preferred risks, torture, even death rather than abandon their Faith.

Thousands walked a hundred miles to freedom. Others set sail in little sampans that were not built for the high winds of the South China Sea. Drenched with salt water, shivering with cold, their skin became dried and cracked; their ankles and feet swollen and bloated. These refugees have had more than their share of suffering and sickness.

WON'T YOU HELP US TO BEGIN A 50-BED HOLY FAMILY HOSPITAL IN VIETNAM FOR THESE REFUGEES NOW? THE FIRST GROUP OF SISTERS ARE READY TO GO THIS MONTH.

S. VIETNAM NEEDS

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- 12 Dozen—Rubber Gloves (Assorted) $5.00 doz.
- 26 Dozen—Syringes (Assorted Sizes) $15.00 doz.
- 144 Thermometers $8.50 doz. $85.75 gr.
- 2 Dozen Covered Instrument Trays $6.30 ea. $63.00 doz.
- 6 Dozen Trays (Assorted) $15.00 doz.
- 6 Dozen Surgical Suture Needles (Assorted) $1.50 doz.
- 34 Dozen Hypodermic Needles (Assorted Sizes) $2.00 doz. $18.50 gr.

MEDICAL MISSION SISTERS, Philadelphia 11, Pa.

Dear Sisters:

Here is my gift $_____ for your hospital in Vietnam.

Name _____

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City _____ Zone _____ State _____

Mary in the Gospels

Blessed art thou among women, and blessed is the
Fruit of thy womb. And whence is this to me that the
mother of my Lord should come to me?—Luke 1:43.

(One of a series)